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106TH CONGRESS
2D SESSION

H. R. 5094

To reduce the amount of paperwork and improve payment policies for health care services, to prevent fraud and abuse through health care provider education, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 27, 2000

Mr. THORNBERRY introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To reduce the amount of paperwork and improve payment policies for health care services, to prevent fraud and abuse through health care provider education, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Care Fraud Prevention and Paperwork Reduction Act of 2000''.

SEC. 2. FEDERAL COMMISSION ON BILLING CODES AND FORMS SIMPLIFICATION.

(a) ESTABLISHMENT.—There is hereby established the Commission on Billing Codes and Forms Simplification (in this section referred to as the ''Commission'').

(b) DUTIES.—The Commission shall make recommendations regarding the following:

(1) STANDARDIZED FORMS.—Standardizing credentialing and billing forms respecting health care claims, that all Federal Government agencies would use and that the private sector is able (and is encouraged, but not required) to use.

(2) REDUCTION IN BILLING CODES.—A significant reduction and simplification in the number of billing codes.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of such members as the Comptroller General of the United States shall appoint.

(2) QUALIFICATIONS.—The membership of the Commission shall include individuals who are members of the medical community.

(d) INCORPORATION OF MEDPAC PROVISIONS.—The provisions of paragraphs (3) through (6) of subsection (c) and subsections (d) through (f) of section 1805 of the So-

cial Security Act (42 U.S.C. 1395b–6) shall apply to the Commission in the same manner as they apply to the Medicare Payment Advisory Commission.

(e) REPORTS.—The Commission shall submit to Congress and the President such periodic reports on its recommendations as it deems appropriate.

SEC. 3. EDUCATION OF PHYSICIANS AND PROVIDERS CONCERNING MEDICARE PROGRAM PAYMENTS.

(a) WRITTEN REQUESTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a process under which a physician may request, in writing from a carrier, assistance in addressing questionable codes and procedures under the medicare program under title XVIII of the Social Security Act and then the carrier shall respond in writing within 30 business days respond with the correct billing or procedural answer.

(2) USE OF WRITTEN STATEMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), a written statement under paragraph (1) may be used as proof against a future audit or overpayment under the medicare program.

(B) LIMIT ON APPLICATION.—Subparagraph (A) shall not apply retroactively and shall not apply to cases of fraudulent billing.

(b) RESTORATION OF TOLL-FREE HOTLINE.—

(1) IN GENERAL.—The Administrator of the Health Care Financing Administration shall restore the toll-free telephone hotline so that physicians may call for information and questions about the medicare program.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out paragraph (1).

(c) DEFINITIONS.—For purposes of this section:

(1) PHYSICIAN.—The term ''physician'' has the meaning given such term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(2) CARRIER.—The term ''carrier'' means a carrier (as defined in section 1842(f) of the Social Security Act (42 U.S.C. 1395u(f))) with a contract under title XVIII of such Act to administer benefits under part B of such title.

SEC. 4. POLICY DEVELOPMENT REGARDING E&M GUIDELINES UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—HCFA may not implement any new evaluation and management guidelines (in this section

referred to as ''E&M guidelines'') under the medicare program, unless HCFA—

(1) has provided for an assessment of the proposed guidelines by physicians;

(2) has established a plan that contains specific goals, including a schedule, for improving participation of physicians;

(3) has carried out a minimum of 4 pilot projects consistent with subsection (b) in at least 4 different HCFA regions (to be specified by the Secretary) to test such guidelines; and

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines.

(b) PILOT PROJECTS.—

(1) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be of sufficient length to allow for preparatory physician and carrier education, analysis, and use and assessment of potential E&M guidelines; and

(B) be conducted, throughout the planning and operational stages of the project, in consultation with national and State medical societies.

(2) PEER REVIEW AND RURAL PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians which evaluates medical record information for statistical outlier services relative to definitions and guidelines published in the CPT book, instead of an approach using the review of randomly selected medical records using non-clinical personnel; and

(B) at least one shall be conducted for services furnished in a rural area.

(3) STUDY OF IMPACT.—Each pilot project shall examine the effect of the E&M guidelines on—

(A) different types of physician practices, such as large and small groups; and

(B) the costs of compliance, and patient and physician satisfaction.

(4) REPORT ON HOW MET OBJECTIVES.—HCFA shall submit a report to the Committees on Commerce and Ways and Means of the House of Representatives, the Committee on Finance of the Senate, and the Practicing Physicians Advisory Council, six months after the conclusion of the pilot

projects. Such report shall include the extent to which the pilot projects met the objectives specified in subsection (c).

(c) OBJECTIVES FOR E&M GUIDELINES.—The objectives for E&M guidelines specified in this subsection are as follows (relative to the E&M guidelines and review policies in effect as of the date of the enactment of this Act):

(1) Enhancing clinically relevant documentation needed to accurately code and assess coding levels accurately.

(2) Reducing administrative burdens.

(3) Decreasing the level of non-clinically pertinent and burdensome documentation time and content in the record.

(4) Increased accuracy by carrier reviewers.

(5) Education of both physicians and reviewers.

(6) Appropriate use of E&M codes by physicians and their staffs.

(7) The extent to which the tested E&M documentation guidelines substantially adhere to the CPT coding rules.

(d) DEFINITIONS.—For purposes of this section and sections 5 and 6:

(1) PHYSICIAN.—The term ''physician'' has the meaning given such term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(2) CARRIER.—The term ''carrier'' means a carrier (as defined in section 1842(f) of the Social Security Act (42 U.S.C. 1395u(f))) with a contract under title XVIII of such Act to administer benefits under part B of such title.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) HCFA.—The term ''HCFA'' means the Health Care Financing Administration.

(5) MEDICARE PROGRAM.—The term ''medicare program'' means the program under title XVIII of the Social Security Act.

SEC. 5. OVERPAYMENTS UNDER THE MEDICARE PROGRAM.

(a) INDIVIDUALIZED NOTICE.—If a carrier proceeds with a post-payment audit of a physician under the medicare program, the carrier shall provide the physician with an individualized notice of billing problems, such as a personal visit or carrier-to-physician telephone conversation during normal working hours, within 3 months of initiating such audit. The notice should include suggestions to the physician on how the billing problem may be remedied.

(b) REPAYMENT OF OVERPAYMENTS WITHOUT PENALTY.—The Secretary shall permit physicians to repay medicare overpayments within 3 months without penalty or interest and without threat of denial of other claims based upon extrapolation. If a physician should discover an overpayment before a carrier notifies the physician of the error, the physician may reimburse the medicare program without penalty and the Secretary may not audit or target the physician on the basis of such repayment, unless other evidence of fraudulent billing exists.

(c) TREATMENT OF FIRST-TIME BILLING ERRORS.—If a physician's medicare billing error was a first-time error and the physician has not previously been the subject of a post-payment audit, the carrier may not assess a fine through extrapolation of such an error to other claims, unless the physician has submitted a fraudulent claim.

(d) TIMELY NOTICE OF PROBLEM CLAIMS BEFORE USING EXTRAPOLATION.—A carrier may seek reimbursement or penalties against a physician based on extrapolation of a medicare claim only if the carrier has informed the physician of potential problems with the claim within one year after the date the claim was submitted for reimbursement.

(e) SUBMISSION OF ADDITIONAL INFORMATION.—A physician may submit additional information and docu-

mentation to dispute a carrier's charges of overpayment without waiving the physician's right to a hearing by an administrative law judge.

(f) LIMITATION ON DELAY IN PAYMENT.—Following a post-payment audit, a carrier that is conducting a pre-payment screen on a physician service under the medicare program may not delay reimbursements for more than one month and as soon as the physician submits a corrected claim, the carrier shall eliminate application of such a pre-payment screen.

SEC. 6. ENFORCEMENT PROVISIONS UNDER THE MEDICARE PROGRAM.

If a physician is suspected of fraud or wrongdoing in the medicare program, inspectors associated with the Office of Inspector General of the Department of Health and Human Services—

(1) may not enter the physician's private office with a gun or deadly weapon to make an arrest; and

(2) may not make such an arrest without a valid warrant of arrest, unless the physician is fleeing or deemed dangerous.

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